MANGO Medical Clinic
4392 Beresford St, Burnaby V5H 0E7 | T: 778-379-4392 | F: 778-379-4391 | www.mangomedical.ca

Form C: Pediatric Health History Form

Date_____

Your answers on this form will be kept confidential, and they will help your healthcare provider get an accurate history of your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Thank you!

A: DEMOGRAPHIC

Last name	
First name	
Date of birth	
Gender	
Adddress	
Personal Health Number (PHN)	
Contact person	
Primary phone	
Secondary phone	
Email	
Emergency contact name	
Emergency contact number	
Name of Parents	
Name of Guardians if different from Parents	

B: PAST MEDICAL HISTORY

1. Where were you getting your care before?

2. Do you see any specialist doctors such as a pediatrician? Please list their name and specialty:

3. What past medical issues do you have? (For example, asthma, skin conditions, diabetes, celiacs disease...

4. What surgeries have you had in the past? (For example, appendix, gall bladder, tonsil surgeries…)

5. What medications do you take?

Medication	Dosing	What for?

6. What allergies do you have?

C: FAMILY HISTORY

Do you have any family history of

- heart attack ☐No ☐Yes, who:_____
- diabetes ☐No ☐Yes, who:_____
- stroke ☐No ☐Yes, who:_____
- hip fractures ☐No ☐Yes, who:_____
- breast cancer ☐No ☐Yes, who:_____
- colon cancer ☐No ☐Yes, who:_____
- other cancers ☐No ☐Yes, who:_____
- thyroid problems ☐No ☐Yes, who:_____
- rheumatological issues ☐No ☐Yes, who:_____
- hepatitis ☐No ☐Yes, who:_____
- anxiety ☐No ☐Yes, who:_____
- depression ☐No ☐Yes, who:_____
- bipolar ☐No ☐Yes, who:_____
- schizophrenia ☐No ☐Yes, who:_____
- suicide ☐No ☐Yes, who:_____
- alcohol or substance abuse ☐No ☐Yes, who:_____
- Other significant medical issues in your family:

D: SOCIAL HISTORY

1. Where do you attend school?

2. Who lives at home with you?

3. Do you have dietary restrictions?

4. Are you vegetarian?

5. Do you consider yourself to have a sedentary lifestyle?

6. Do you have any family members in our clinic? Who are they?

Do you have anything else you would like us to know about you?

E: FOR PATIENTS AGED 0-12:

What was your birth weight?

What was your birth length?

What was your birth head circumference?

How many weeks gestation were you born?

How were you delivered (vaginal birth, vacuum or forceps, or cesarean section)?

Was there any complications during the pregnancy or around the time of labor?